Dialysis Reimbursement Meeting

Department of Medical Assistance Services
13th Floor Board Room
Monday, May 16, 2005
12:00-1:00 pm

Minutes

Attendees:	**DMAS Staff:**
M. Guy Rohling	**Scott Crawford**
Leonard J. Coulombe	**Steve Ford**
Kathleen T. Smith	**Sally Rice**
Harold Jacks	**Carla Russell**
	Chandra Shrestha
	Bonnie Winn

Welcome/Introductions

Steve Ford opened the meeting for roundtable introductions.

Scope of Meeting

Steve Ford stated the purpose of the meeting as the introduction and discussion of the budget item regarding the study of the history of dialysis reimbursement rates and referred to the copy of the budget item distributed. Mr. Ford stated that we (DMAS) were assembled to hear concerns that the providers may have regarding reimbursement.

Presentation from Provider Representatives

Kathleen Smith representing Fresenius Medial Care stated that Virginia Medicaid from a provider perspective is a consistent payer. She also stated the Virginia Medicaid is a fair payer. She said dialysis providers are the only Medicare providers whose rates are not updated regularly and that until recently Medicare had not updated dialysis rates.

Ms. Smith stated that Fresenius has 2,500 patients in Virginia. She said Medicare is the primary payer for their patients and only 5% do not meet Medicare eligibility. Ms. Smith indicated that nationally 40% of their patients are dual eligible and in Virginia 25% are dual.

Ms. Smith stated that ESRD is not a mandatory program under Title XVIV. She said that patients received treatment three times a week for four hours each time. She indicated that transportation is an issue. Ms. Smith stated that other states are eliminating spenddown. She further stated that they are concerned about the spenddown and the effects on entitlement and benefit cuts. As an aside, Ms.

Smith requested information on how to identify a Medicaid patient. Bonnie Winn stated that Ms. Smith could contact her for the information.

Guy Rohling representing Albers & Company stated that in 2003 and 2004 many people had begun to look at optional services for Medicaid. He said large national legislative groups developed bills regarding dialysis reimbursement and that these groups had suggested biennial rebasing of dialysis reimbursement rates. Mr. Rohling stated that Delegate Phil Hamilton's committee had also examined optional services, e.g.- elimination of transportation and/or dialysis limitations. He indicated that the National Black Caucus of State Legislators has also been involved in activities surrounding Medicare's dialysis reimbursement policies.

Ms. Smith concurred that the Native American and Black populations are most affected by dialysis reimbursement policies. She stated that diabetes and hypertension are leading causes of renal failure.

Mr. Ford asked the provider representatives about the Virginia Medicaid's reimbursement rates.

Leonard Coulombe of DaVita stated DMAS's rates were competitive with Medicare. He indicated that 70% to 75% of DaVita's patients are Medicare primary but only comprise 50% of their revenue. He said only 25% to 30% of their patients are in managed care programs. Mr. Coulombe stated that Medicare and Medicaid reimbursement do not cover the costs associated with Medicare primary patients. He indicated that the managed care patients from both commercial and Medicare programs subsidize the low reimbursement received for Medicare and Medicaid patients.

Ms. Smith stated that the Title XVIV issues were addressed in MedPAC studies.

Open Discussion of Issues Related to Reimbursement

Ms. Russell asked the provider representatives about the origin of the Virginia Medicaid reimbursement rates.

Ms. Smith indicated that the rate set in 1983 was rebased in the late 1990s based on 1997 cost reports. She stated that in the 1990s the separately billable medications were paid according to Average Wholesale Price (AWP). She said and Mr. Coulombe confirmed that the pricing for the dialysis drugs were well exceeded that costs of providing the drugs. Ms. Smith stated that the overpayment of the drugs offset the losses on the composite rate that was rarely updated. DMAS concurred that the list of separately billable drugs was not the same as Medicare and AWP rates compensated for the static flat rate.

Ms. Smith and Mr. Coulombe stated that they were satisfied with the reimbursement received from Virginia Medicaid on the crossover claims for the 20% of the patients' care that Medicare did not cover. Both were unclear regarding reimbursement for patients that did not have Medicare primary coverage.

Mr. Coulombe discussed Epogen and Medicare's use of the hematocrit levels to determine payment. He suggested that CMS should be advised to change their limitations regarding payment of this drug because patients reported feeling much sicker than originally thought when the hematocrit levels reached the mid to low thirties. He stated that if the patient's hematocrit levels were below the accepted range Medicare had no gray area would deny payment for an entire month based on one reading. Bonnie Winn stated that DMAS does not limit Epogen.

The provider representatives expressed concern regarding the implementation of the Average Sales Price (ASP) versus AWP. Sally Rice confirmed that DMAS just updated to Medicare's ASP rates in April 2005. The provider representatives stated that ASP in relation to Average Acquisition Cost is not comparable to AWP and may be less.

The group discussed the potential for Virginia Medicaid's rates to no longer be competitive with Medicare with the introduction of the updates to the ESRD program and Medicare Part D, specifically the attempt to eliminate cross-subsidization by drug reimbursement rates.

Adjournment

Steve Ford adjourned the meeting.